THE EPISCOPAL CHURCH MEDICAL TRUST

445 Fifth Avenue
New York, NY 10016
Active Member Services: (800) 480-9967
Fax: (212) 592-9499
www.cpg.org

Employee Group Medical and Dental Enrollment Form

RETURN COMPLETED FORM TO: Episcopal Diocese of Iowa, 225 37th Street, Des Moines, IA 50312

1 Information About the Employee

❏ New Employee (See Enrollment Guidelines on back)
❏ Late Enrollment (Include Health Statement)

______ Years of credited service (retirees only)

Date Hired ___/___/___ Mo / Day / Yr

Coverage Effective ___/___/___ Mo / Day / Yr

Title (The Rev., Mr., Mrs., Ms., etc.) First Name M.I. Last Name

Birth Date ___/___/___ Mo / Day / Yr

Soc. Sec. No. ___-___-___

Residence

Street

City State Zip

Home Phone E-mail

Mailing Address (if different)

Street

City State Zip

❏ Male
❏ Female

❏ Married
❏ Single

❏ Clergy
❏ Lay

❏ Seminarian

2 Billing Information for Medical and Dental Plans

Name of Organization

Phone E-mail List Bill ID

Street

City State Zip

Billing Instructions:

Send bill to the attention of ____________________

3 Active Medical Coverage

Name of Plan Carrier Type of Plan (HMO, PPO, etc.)

❏ Medical coverage declined

Tier: ❏ Single ❏ Employee + 1 (spouse) ❏ Employee + child ❏ Employee + children ❏ Family

4 Dental Coverage

Not available in Iowa

Name of Plan Carrier Type of Plan (Preventative, $25, $50, etc.)

❏ Dental coverage declined

Tier: ❏ Single ❏ Employee + 1 (spouse) ❏ Employee + child ❏ Employee + children ❏ Family

5 Retiree Medical Coverage

Name of Plan Choice for Retiree Retirement Date (Mo/Day/Yr)

Name of Plan Choice for Spouse Date of Marriage (Mo/Day/Yr)*

***Include copies of legal marriage documents**

6 Information About Your Dependents

List dependents and check coverage desired. Dependents 19 and over (full-time students,etc.) may be eligible – check Administrative Guidelines for your diocese or organization. If your group offers domestic partnership coverage, attach supporting documentation with this form. For more space, attach an additional Enrollment Form.

Coverage	Full Name	Relationship	Soc. Sec. No.	Birth Date (M/D/Y)	Gender
❑ Medical ❑ Dental			- -	/ /	❑ M ❑ F
❑ Medical ❑ Dental			- -	/ /	❑ M ❑ F
❑ Medical ❑ Dental			- -	/ /	❑ M ❑ F

7 Signatures – Employee, Employer, and Sponsoring Diocese or Organization

The employee, employer, and an officer of the sponsoring diocese or organization must sign this form. By signing, the Employer certifies the employee is eligible for all coverages applied for, and, to the best of the employer's knowledge, all information provided is correct.

Employee's Signature* Date

Employer's Signature Date

Episcopal Diocese of Iowa

Name of Sponsoring Diocese or Organization

Officer's Signature Date

225 37th Street, Des Moines, IA 50312 515-277-6165 diocese@iowaepiscopal.org

Street City State Zip Phone E-mail

***Include Power of Attorney documentation if applicable.**

8 Enrollment Guidelines

- For Group Medical Benefits, if the Health Insurance Portability and Accountability Act of 1996 (HIPAA) applies, you must include evidence of your prior health coverage with this form.
- New employees must enroll and sign this form within 30 days of hire or eligibility date for Group Medical/Dental Insurance.
- If enrolling in a Managed Care Plan, attach Managed Care application. Managed Care plans do not accept late enrollments.
- All late enrollments subject to approval.